

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN8204	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/25/2013
NAME OF PROVIDER OR SUPPLIER GREYSTONE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 181 DUNLAP ROAD, PO BOX 1133 BLOUNTVILLE, TN 37617		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey conducted on February 25, 2012, no licensure deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.		N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator TITLE

3/15/13

(X6) DATE

STATE FORM

6890

VOPK21

If continuation sheet 1 of 1

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